Dialogues in Philosophy, Mental and Neuro Sciences

In collaboration with the Section Philosophy & Psychiatry
of the European Psychiatric Association

Crossing Dialogues Association

ORIGINAL ARTICLE

Phenomenology of delusional hypochondriasis as a sixth form of somatization in immigrants

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ABSTRACT

Background. Somatization is frequently observed among migrants, especially in primary care. One problem is that patients with somatization are often different, the same label including different psychopathological syndrome. Previous phenomenological research has identified five different types of somatization syndromes in immigrants (anxious hypochondriasis, somatization with culture playing a pathogenetic role, somatization with pathoplastic effects of culture, somatization in adjustment reactions to migratory living difficulties, and somatization as post-traumatic reaction). This article adds evidence to previous research with a phenomenological description of a sixth type of somatization in immigrants: delusional hypochondriasis.

Methods. The description was based on seven levels: medical examination, description of somatization symptoms, the patients' interpretation of their somatic experience, associated psychopathological phenomena, genetic understanding, clinician's interpretation, and course and treatment.

Results. Two cases of delusional hypochondriasis are presented, a man from Africa and a woman from Eastern Europa. The analysis of the cases shows that the understandable basis of the future delusion is the experience of an alarming event that radically changes the trust in the naturalness of the lived bodily experience, as well as the interpersonal trust. It is in this experience of suspension of habitual meanings, with an atmosphere of radical insecurity, that the delusional development starts. The possible role of culture in the way these events are experienced is discussed. Later, progressive jumps of meaning occur, increasing the oddity of the somatic experience, leading to bizarre delusions. The consequences for both psychopathological theory and clinical management are also discussed.

KEYWORDS: Somatization, Migrants, Ideal-typical approach, Somatic type delusional disorder

ARTICLE HISTORY
Received: July 23, 2025
Accepted: August 23, 2025
Firstly published online: November 07, 2025

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DIAL PHIL MENT NEURO SCI 2025; 18(1):5-12

INTRODUCTION

Somatizations are a frequent way to express distress in immigrants. For example, in primary care outpatient services for immigrants, the prevalence is around 25%, with higher rates among South Americans (30.1%) (Aragona et al., 2012). The prevalence and correlates of somatization vary across different immigrant groups depending on several variables: variation in reasons for migration, stress exposure, explanatory models of illness, coping, and other individual factors

(Lanzara et al., 2019). Moreover, somatization is a frequent way to express distress also in traumatized migrants, as it is often the case for asylum seekers and refugees (Aragona et al., 2010). Finally, the post-migration living difficulties can have a significant detrimental effect on somatization among immigrants (Aragona et al., 2011).

Despite the importance of these studies in addressing the phenomenon, one of the main limitations is that the patients included in the somatizers group are those who obtain a score above a cut-off in a self-assessment questionnaire. This raises the possibility that there may be bias related to the heterogeneity of the selected sample. Indeed, it is possible that not all the somatizations thus identified are part, if we look closely, of the same psychopathological syndrome. For example, Tseng and Bartocci (2013) explored how different cultures express psychological distress, particularly in cases of somatization (where psychological symptoms manifest as physical problems). This is a common theme in transcultural psychiatry, where non-Western populations may express psychological discomfort through the body rather than through psychological language.

To address this problem, it is necessary to go beyond quantitative questionnaires and carry out qualitative analyses of the clinical specificities presented by individual patients. A pioneering study on this topic was conducted using a methodology based on the concept of ideal type (Aragona et al. 2024). This approach made it possible to identify five different types of somatization in migrants: 1. Anxious hypochondriasis; 2. Somatization with cultural features playing a pathogenetic role; 3. Culturally shaped somatization (through pathoplastic effects); 4. Somatization as part of adjustment reaction due to migratory living difficulties; and 5. Somatization as post-traumatic reaction. The model assumes that the list is not exhaustive, and that further research may identify and add new types.

In this article, we analyse two clinical case that came to our attention, in which we observed the coexistence of two factors that are rarely studied together: migration and delusional hypochondriasis.

Delusional hypochondriasis (also called *somatic type delusional disorder*) is a psychiatric condition characterized by a fixed, false belief that one is seriously ill or afflicted by a severe medical condition, despite medical evidence to the contrary and reassurance from health professionals. Unlike common health anxiety or hypochondriasis, in delusional hypochondriasis the conviction is unshakeable and persistent, often leading to significant distress and impairment. One requirement for this diagnosis is that delusions are not bizarre and cannot be classified as organic, schizophrenic or affective. However, it is often difficult to decide about bizarreness in these cases. For example, one study reports the clinical case of a 59-year-old woman who was admitted to a dermatology department because she was convinced that, following a mosquito bite that occurred 7 years earlier, she had multiple purulent skin lesions on her back that had spread to her internal organs (Kepska et al., 2011). It was quite easy to exclude the presence of organic lesions: dermatological examinations did not reveal any significant skin lesions, apart from a small scar on the back, formed following intense scratching. But could we say the same about the non-bizarreness of the conviction that she had skin lesions on her back spreading to the internal organs? We will see that in our clinical cases the supposed non-bizarreness of the delusional hypochondriasis is questioned.

METHOD

In this study we use an idealtypical approach, which is a qualitative way to explore the clinical presentations of mental phenomena with the aim of identifying 'pure', ideal cases. The method is inspired by Weberian ideas, and it has been widely used in psychopathological research on mental disorders (Schwartz & Wiggins, 1987). The result is a description of typical, idealized cases that capture the essential aspects of the phenomena, with particular attention to the similarities and differences between cases.

For this study, we selected two specific case, two patients referred to our outpatient service for immigrants and people in poverty. The organization of the clinics is based on a multidisciplinary model. In the first case, the patient was initially visited by the GP (general pratictioner), who then contacted the psychologist who joined the visit. In the second case, one gynaecologist, a psychologist and a social worker were involved. Starting from the concrete clinical cases, an abstraction was performed (idealization) to make it possible to generalize the information.

The clinical material was organized into several levels: 1. Medical examination; 2. Description of the somatization symptoms; 3. The patient's own interpretation of their somatic experience; 4. Description of any co-occurring psychopathological phenomena; 5. The possibility of a clinician's genetic understanding; 6. The clinician's interpretation based on theoretical frameworks and hypotheses about possible psychological mechanisms; 7. The course of the treatment.

To describe the psychopathological phenomena, we applied the methods and concepts from classic European descriptive psychiatry. Our exploration of a possible genetic understanding drew on ideas about meaningful connections (Jaspers, 1913). The psychological interpretation involved multiple theoretical sources, depending on the specific case and the sensibility of the psychologist involved.

To ensure privacy, we have changed names and other identifying details to keep the case unrecognizable.

Case study 1

Medical examination and somatization symptoms. A 43-year-old Nigerian man has a second contact with the outpatient primary care of our medical service. He says he has a wife, met in Nigeria, who lives in France. They have two children, aged 6 and 3, whom he sometimes meets in France, sometimes in Italy. He speaks fluently only English, not Italian, despite having lived in Italy for 10 years. He worked until recently, when he had to take a leave due to the current health problem. The general medical service of the facility, to which the patient turned for a problem that began in January 2025, found no somatic pathologies and sent him for a psychological evaluation. Apparently, the first time the patient focused his attention on physical symptoms was six months ago, when he had breakfast in a bar. He says he realized immediately after that something had happened to his body: the patient had started vomiting blood and feeling a sensation in his bones that he had never felt before. Since then the patient has been afraid of feeling ill again and has developed the following delusional ideas about this event and its consequences.

Patient's interpretation of his somatic experience. He was very scared and worried, convinced that a woman working at the bar had put something in his drink that had made him sick (delusional interpretation). After the first episode of vomiting, the patient began to believe that it could happen again if exposed to metals. He cannot come into contact with metals, because they cause "uncontrollable reactions" in his body. Although there is no known reason why he linked metals to the illness, the patient is nevertheless firmly and unshakably convinced of it. For this reason, the patient avoids direct skin contact with metals, for example by covering metal objects, such as coins, with a non-metallic material (cloth or paper). During the interview, the psychologist asked the patient to try to hold a coin in his hand. The patient did so, without any particular somatic reactions due to contact with the metal. Despite this evidence, he remained convinced that he had to protect himself from metals, that his somatic reactions were real, and that his problem was exclusively medical.

Other psychopathological phenomena. As far as it was possible to understand during a single psychological interview, there did not seem to be any other psychopathological phenomena worthy of note. In particular, the state of consciousness appeared lucid and no hallucinations were detected. His mood seemed dysphoric, but in a reactive way: for example, he was angry with the doctors and the psychologist who, in his opinion, were not paying enough attention to his somatic illness.

Genetic understanding. It is understandable that the loneliness associated with migrant life, with family far away, may have created an emotional atmosphere in which interpersonal relationships could be seen as potentially dangerous. One might also think that poisoning and influencing may have a connection with beliefs tied to the culture of origin. However, the shift from situational fear to a general belief that all metal should affect him starts loosing contact with the original situation. The patient himself strongly emphasizes that his problem has nothing to do with cultural beliefs, but is exclusively a medical problem. Therefore, even if one can understand the situation of stress and interpersonal mistrust that underlies this reaction, the leap that leads to the delusional belief that one has been poisoned and the further leap that leads from the initial poisoning to hypersensitivity to metals remain *non-understandable*. Even the generalization of the delusion, from a specific event (the poisoning) to a possible contact with all metals (so much, so that he lost his job because there he was inevitably in contact with metals) remain non-understandable at a first interview.

Treatment and course. There is not much evidence on this point. The medical visits have excluded any somatic problems and therefore no further visits are planned. It is likely that the patient, convinced of having a medical condition but dissatisfied with the answers received, may return again to ask for further information, or go elsewhere. Regarding mental health, the patient refused the possibility of activating a psychiatric consultation. He showed good availability for the psychological interview and was invited to return. However, he did not make a new appointment so we do not know if he will return later.

Clinicians' interpretation. One psychological interview is not enough to propose a sound interpretation of the underlying psychological dynamics. The risk is to use a theory to fill the gap. In the genesis of this delusion, we can hypothesize the role of several factors. Among these, the post-migration living difficulties, added to a profound loneliness, could have contributed to the genesis of an experience of interpersonal distrust. The fear of feeling sick and vomiting

blood may have increased attention towards the body, accentuating the inspection of the "body-object" (*Körper*) and relegating the experienced body (*Leib*) to the background. The possible conflict between his traditional view and Western medical beliefs about disease and treatment may also have played a role. However, these are only hypotheses, since our knowledge of the person is not yet sufficient to understand his delusion.

Case study 2

Medical examination and somatization symptoms. A 40-year-old East Europe woman has a first contact with the social worker of our medical service. She speaks Italian fluently, having lived in Italy for years. Her husband and children suffer from severe medical diseases but she focuses exclusively on her concerns about her own disease. The patient had been suffering from pelvic pain for 11 years. Despite several accesses in Emergency Departments and inpatient hospitalizations, all medical investigations were unable to find a medical explanation for her symptoms. In a following multidisciplinary team discussion, we decided to start with an initial gynecological examination (which was the patient's request) and to include the psychologist in the setting, to help the gynecologist to understand and manage psychological issues.

Apparently, the first time the patient directed her focus on gynecological symptoms had been during the birth of a daughter, when the patient underwent Caesarean section. She recalls have seeing and hearing the doctors alarmed about how the operation was going. From that moment, the patient began to complain of vaginal bleeding, fainting spells, and severe pain in her lower abdomen.

Patient's interpretation of her somatic experience. She was very worried, believing that the doctors were not taking seriously her symptoms and did not prescribe the right medical examinations to confirm them.

Other psychopathological phenomena. Besides the symptoms reported above, during the interview the patient reported losing pieces of metal from her vagina while taking care of her personal hygiene. The symptoms were not just part of an anxious focus on bodily sensations, with a delusional development . After the first episode in which she was scared about the Caesarian section, she started believing that doctors were not serious because they were not looking with due care to her symptoms. After some time, this basic lack of trust morphed into a belief that they were against her: the pieces of metal coming out from her vagina were part of a medical instrument the doctors had covertly inserted into her body to stop her from getting pregnant again. The evidence that no doctors that had visited her in the following years had found neither hemorrhages nor pieces of metal was not changing her idea. She explained the evidence as a sign of lack of accuracy or malicious behavior (e.g. wanting to cover up the misconduct of previous colleagues). As a result, the patient had made several complaints to the police. In addition to these delusional ideas, the patient was also sure that the doctors were not treating her children carefully, so she filed several complaints for this too.

Genetic understanding. It could be possible to empathize with the anxiety aroused by the emotional atmosphere during the Caesarian section. We actually do not know if she really heard the alarmed comments made by the doctors or if she was so frightened to have just had the impression to hear them. In this second case, it could be an overinterpretation of something really said or the hallucinatory experience concretizing her extreme fear. In all cases, we are

still within the field of a preserved genetic understanding, the phenomena arising as a coherent reaction to the basic emotional ground. It may be quantitatively too much, but it remains qualitatively understandable. Instead, the shift from the situational fear to the consequent persuasion that the doctors (in general, as a category) were inaccurate in their examinations and essentially uninterested in her illness, starts loosing contact with the original situation. It is still partially understandable as a reaction to the concerns for her health and the distress for not finding a solution, but in its detachment from concrete situations, undue generalization and conviction, it is already turning in a first delusional nucleus. Furthermore, there is a final cut when this delusional nucleus, still partially understandable, is transformed into a persecutory delusion of harm. Now in her mind the doctors *intentionally* put a metal instrument into her body to stop her from having children. The somatic experience detaches itself from proprioception to become the hallucinatory evidence of metal pieces coming out of the vagina. At this stage, the genetic comprehensibility, i.e. the continuity of the meaningful chain, is totally lost!

Treatment and course. After the first joint gynecological and psychological interview, the patient did not come to follow-up visits. The treatment was not started and we are unable to give information about the following course. Considering that the last delusional stage described above was stable in the last here, we can assume that the course should not be changed after our visit.

Clinicians' interpretation. Also in this second case, one psychological interview is not enough to propose a sound interpretation of the underlying psychological dynamics. We can fantasize about the role of her experience as a foreigner in the genesis of this delusion. Or on the role of the contrast between her religious and ethical beliefs on the importance of having many children at one side, and the secularized Italian society, where the birth rate is at historic lows, on the other side. This may at least partially explain why she felt misjudged and believed that doctors wanted to prevent her from having any more children. But if this makes the content at least partially understandable, the formal leap from an idea that came to mind to an unshakeable delusional conviction remains. What kind of basic personality, what peculiar way of "being in the world" is necessary to interpret the events in this way? On this, our knowledge of the person remains insufficient.

DISCUSSION

This study presents two cases of delusional hypochondriasis in migrants (a man from Africa and a European woman).

The first thing to note is that, despite coming from very different countries, the two stories have some similarities. For example, in both cases an alarming event occurs that radically changes both the trust in the naturalness of the lived bodily experience (*Leib*) and the interpersonal trust. It is as if the person experiences a suspension of habitual meanings, in an atmosphere of radical insecurity. This could be the understandable basis on which the no longer understandable leap into the delusional explanation is grafted. Less evident in the first case, clearer in the second, but present in both, we witness a progressive path in which, through successive leaps, the delirium expands from the original circumstances towards increasingly bizarre explanations that generalize to multiple situations.

The second point is related to the role of cultural beliefs. A common theme in transcultural psychiatry regards the possibility that non-Western populations may express psychological discomfort through the body rather than through psychological language. The role of culture in the origin of some syndromes, together with a reaction to life difficulties, has been frequently emphasized (e.g., Tseng et al, 2013). While Western societies tend to view psychiatric disorders as individual and psychological phenomena, in many other cultures they are seen as manifestations of social, spiritual, or familial disharmony. A recurring theme is the tension between universal diagnostic criteria (such as those in the DSM) and the need for diagnoses that are more sensitive to cultural differences. Tseng (2001) argued that a cultural understanding of mental distress is essential to avoid incorrect or stigmatizing diagnoses. In our two cases, the cultural origin of symptoms is not sure. The similarities found in these cases with different cultural background suggest that a component can be more transcultural. However, also in these two cases the initial triggers could be related to a conflict of values between the culture of origin and that of the host country. This is not sufficient to explain the delusional development of the symptoms, but can highlight some dynamics at the basis of the delusional onset. For now, this is only a hypothesis, but in the future it should be explored more deeply.

Thirdly, it should be emphasized that while these cases rarely reach the psychiatrist, they are quite frequent in medical offices (GP or other specialists). In general, physicians find it difficult to identify the kind of somatization the patient is presenting, and mental health experts can be useful to identify, characterize and try to heal somatizers. In the specific cases of this study, the delusional character of the somatization makes it even more difficult to find a way to help the person. Considering that the patient usually refuses to be referred to a following visit with a psychiatrist/psychologist for further assessment, a possible alternative is to include the psychologist within the medical setting. This could be helpful because it increases the likelihood that the patient may perceive the psychologist as one member of the staff, thus 'normalizing' its role.

Finally, in-depth qualitative research on this type of somatizers can contribute to the theoretical debate. For example, our cases show that the DSM requirement of non-bizarre delusions is problematic, because in cases like ours the somatic complaint progressively tend to evolve into a more bizarre form (e.g., losing pieces of metal from the vagina). To say that at the beginning the patient is a case of somatic type delusional disorder and later a case of schizophrenia is nonsensical. Sharp categorical cuts do not help in the understanding of these patients, while it is helpful a more in depth qualitative exploration of the evolution of symptoms with time, from initial almost-understandable reactions to their transformation into non-bizarre delusional ideas and then a progression with increasing bizarreness.

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